

TBM-DISC – CASE REPORT FORM: CLINICAL DATA (V2.2)

DEMOGRAPHICS

Study Number _____		
Age at presentation _____	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Home Area _____
Hospital site AH <input type="checkbox"/> EDH <input type="checkbox"/> GH <input type="checkbox"/> IALCH <input type="checkbox"/> KEH <input type="checkbox"/> MGMH <input type="checkbox"/> RKKH <input type="checkbox"/>		Ethnicity _____

SYMPTOMS ON ADMISSION (Y = YES, N = NO, NR = NOT RECORDED)

Length of illness ____ Days or NR <input type="checkbox"/>	Seizures Generalised <input type="checkbox"/> Focal <input type="checkbox"/> None <input type="checkbox"/>	Fever Y <input type="checkbox"/> N <input type="checkbox"/>
Headache Y <input type="checkbox"/> N <input type="checkbox"/> NR <input type="checkbox"/>	Photophobia Y <input type="checkbox"/> N <input type="checkbox"/> NR <input type="checkbox"/>	Poor weight gain Y <input type="checkbox"/> N <input type="checkbox"/> NR <input type="checkbox"/>
Vomiting Y <input type="checkbox"/> N <input type="checkbox"/> NR <input type="checkbox"/>	Fatigue/red. playfulness Y <input type="checkbox"/> N <input type="checkbox"/> NR <input type="checkbox"/>	Night sweats Y <input type="checkbox"/> N <input type="checkbox"/> NR <input type="checkbox"/>
Alt consciousness Y <input type="checkbox"/> N <input type="checkbox"/>	Cough > 2 wks Y <input type="checkbox"/> N <input type="checkbox"/> NR <input type="checkbox"/>	Caregiver HIV status Pos <input type="checkbox"/> Neg <input type="checkbox"/> NR <input type="checkbox"/>

CONTACT HISTORY (POS = POSITIVE, NEG = NEGATIVE, UN = UNKNOWN)

Regular/close contact with someone with TB in last year Yes <input type="checkbox"/> No <input type="checkbox"/> Not Recorded <input type="checkbox"/>
Relationship Mother <input type="checkbox"/> Other _____ HIV status of TB contact Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unknown <input type="checkbox"/>

EXAMINATION (Y = YES, N = NO, NR = NOT RECORDED)

Weight _____ kg	Height _____ m	Weight for Age _____ centile
Altered consciousness Y <input type="checkbox"/> N <input type="checkbox"/>	Irritability Y <input type="checkbox"/> N <input type="checkbox"/> NR <input type="checkbox"/>	
Abnormal behaviour Y <input type="checkbox"/> N <input type="checkbox"/> NR <input type="checkbox"/>	GCS ____ or NR <input type="checkbox"/>	
Neck stiffness Y <input type="checkbox"/> N <input type="checkbox"/>	Papilloedema Y <input type="checkbox"/> N <input type="checkbox"/> NR <input type="checkbox"/>	Any focal deficit Y <input type="checkbox"/> N <input type="checkbox"/> NR <input type="checkbox"/>
Abn. posture Y <input type="checkbox"/> N <input type="checkbox"/> NR <input type="checkbox"/>	Abn reflexes Y <input type="checkbox"/> N <input type="checkbox"/> NR <input type="checkbox"/>	
Bulging fontanelle Y <input type="checkbox"/> N <input type="checkbox"/> NR <input type="checkbox"/>	Cranial nerve palsy Y <input type="checkbox"/> N <input type="checkbox"/> NR <input type="checkbox"/>	Increased tone Y <input type="checkbox"/> N <input type="checkbox"/> NR <input type="checkbox"/>

HIV (NR = NOT RECORDED, ND = NOT DONE)

Status Pos <input type="checkbox"/> Neg <input type="checkbox"/> Exposed, a/w result <input type="checkbox"/> Breastmilk cont. exposure <input type="checkbox"/> UN <input type="checkbox"/> Test Date _____	
Last CD4+ Date _____ ND <input type="checkbox"/> Result _____ % or cells/mm ³	Last viral Load Date _____ ND <input type="checkbox"/> Result _____ copies/ml
WHO stage prior to this episode ____ or NR <input type="checkbox"/>	On HAART Yes <input type="checkbox"/> No <input type="checkbox"/> Date commenced _____

BLOOD TESTS BLOOD TESTS PERFORMED WITHIN 72 HOURS OF LUMBAR PUNCTURE (ND = NOT DONE)

Hb _____ g/dL ND <input type="checkbox"/>	WCC Total _____ x10 ⁹ ND <input type="checkbox"/>
Na _____ mmol/L ND <input type="checkbox"/>	Creatinine _____ umol/L ND <input type="checkbox"/> Serum glucose at LP _____ mmol/L ND <input type="checkbox"/>

EXTRANEURAL TB (NR = NOT RECORDED, ND = NOT DONE)

Mantoux Date _____ NR <input type="checkbox"/> ND <input type="checkbox"/>	Induration ____ mm NR <input type="checkbox"/>	Reactive <input type="checkbox"/> Non-Reactive <input type="checkbox"/> NR <input type="checkbox"/>
Specimen Type Sputum <input type="checkbox"/> Gastric Washing <input type="checkbox"/> Lymph node <input type="checkbox"/> Urine <input type="checkbox"/> Ascites <input type="checkbox"/> Other _____		
Results _____		

LUMBAR PUNCTURE (UN = UNKNOWN)

Date				
Opening Pressure (cmH ₂ O)				
Visual (C=clear,S=straw,T=turbid,B=bloody)				
Cell Counts (cells/uL)	P___ L___ E___	P___ L___ E___	P___ L___ E___	P___ L___ E___
Protein (g/L)				
Glucose (mmol/L) / Chloride (mmol/L)	G___ Cl ⁻ ___	G___ Cl ⁻ ___	G___ Cl ⁻ ___	G___ Cl ⁻ ___
TB microscopy (Pos/Neg)				
TB culture (Pos/Neg)				
TB PCR (Neg/Sens/Monores/MDR/XDR)				
Gram Stain/ Bacterial Culture				
India Ink/CLAT				

IMAGING (NR = NOT RECORDED, ND = NOT DONE)

CXR Date_____ ND <input type="checkbox"/>	Lymphadenopathy <input type="checkbox"/> Bronchial Compression <input type="checkbox"/> Miliary pattern <input type="checkbox"/> Pl. effusion <input type="checkbox"/> Consolidation/collapse <input type="checkbox"/> NR <input type="checkbox"/> Other_____		
USS/CT/MRI evidence (extraneural TB) Date_____ ND <input type="checkbox"/>	Type of Scan_____ Result_____ NR <input type="checkbox"/>		
CT-Head/MRI-Head Date_____ ND <input type="checkbox"/>	Normal <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Meningeal enhancement <input type="checkbox"/> Infarct <input type="checkbox"/> Tuberculoma <input type="checkbox"/> Abscess <input type="checkbox"/> NR <input type="checkbox"/> Other_____		

FINAL CLINICIAN DIAGNOSIS

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DRUG TREATMENT (NR = NOT RECORDED)

TB treatment started Y <input type="checkbox"/> N <input type="checkbox"/>	TB drug regimen _____ NR <input type="checkbox"/>
Date TB treatment started_____ NR <input type="checkbox"/>	

OUTCOME (NR = NOT RECORDED)

Response to TB treatment after 3 months Apparent <input type="checkbox"/> Not apparent <input type="checkbox"/> NR <input type="checkbox"/> Not treated <input type="checkbox"/>
Residual Neurological Deficit _____ NR <input type="checkbox"/>
Survived Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> cause of death_____